

		FOR OHF USE					

LLI

**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>8000846</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Fayette County Hospital</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/00</u> to <u>6/30/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>Seventh & Taylor Streets</u> <u>Vandalia</u> <u>62471</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Fayette</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(618)283-1232</u> Fax # <u>(618)283-4608</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () Fax # ()	
IDPA ID Number: <u>37-6012895002</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>1/1/71</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code _____			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name <u>Kenneth Wieduwilt</u> Telephone Number: <u>(618)653-5317</u>			

Facility Name & ID Number Fayette County Hospital# 8000846 Report Period Beginning: 7/1/00 Ending: 6/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>101</u>	Skilled (SNF)	<u>101</u>	<u>36,865</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>101</u>	<u>36,865</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>17269</u>	<u>9981</u>	<u>4919</u>	<u>32169</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17269</u>	<u>9,981</u>	<u>4,919</u>	<u>32,169</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 87.26%D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Meals on WheelsF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 1/1/71J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 18 and days of care provided 4919Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐Tax Year: N/A Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/00 Ending: 6/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	123,952	155,420	66,201	345,573	(125,748)	219,825	0	219,825		1
2	Food Purchase				0	125,475	125,475	0	125,475		2
3	Housekeeping	90,319	16,378	10,594	117,291	(1,575)	115,716	0	115,716		3
4	Laundry	62,548	25,809	5,286	93,643	(81)	93,562	0	93,562		4
5	Heat and Other Utilities				0	135,047	135,047	0	135,047		5
6	Maintenance	47,660	1,391	182,935	231,986	(138,194)	93,792	0	93,792		6
7	Other (specify): Cafeteria				0		0	27,623	27,623		7
8	TOTAL General Services	324,479	198,998	265,016	788,493	(5,076)	783,417	27,623	811,040		8
	B. Health Care and Programs										
9	Medical Director				0		0	0	0		9
10	Nursing and Medical Records	1,371,538	72,979	354,412	1,798,929	(62,074)	1,736,855	41,658	1,778,513		10
10a	Therapy				0		0	256,259	256,259		10a
11	Activities				0		0	0	0		11
12	Social Services	83,227	3,294	11,225	97,746		97,746	0	97,746		12
13	Nurse Aide Training				0		0	0	0		13
14	Program Transportation				0		0	0	0		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,454,765	76,273	365,637	1,896,675	(62,074)	1,834,601	297,917	2,132,518		16
	C. General Administration										
17	Administrative	130,089	676	113,915	244,680	(53,842)	190,838	0	190,838		17
18	Directors Fees				0		0	0	0		18
19	Professional Services				0	32,400	32,400	0	32,400		19
20	Dues, Fees, Subscriptions & Promotions				0		0	0	0		20
21	Clerical & General Office Expenses	11,758	193	330,608	342,559		342,559	0	342,559		21
22	Employee Benefits & Payroll Taxes				0		0	0	0		22
23	Inservice Training & Education				0		0	0	0		23
24	Travel and Seminar				0		0	0	0		24
25	Other Admin. Staff Transportation				0		0	0	0		25
26	Insurance-Prop.Liab.Malpractice				0	21,442	21,442	0	21,442		26
27	Other (specify):*				0		0	0	0		27
28	TOTAL General Administration	141,847	869	444,523	587,239	0	587,239	0	587,239		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,921,091	276,140	1,075,176	3,272,407	(67,150)	3,205,257	325,540	3,530,797		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation				0	68,307	68,307	0	68,307		30
31	Amortization of Pre-Op. & Org.				0		0	0	0		31
32	Interest				0		0	0	0		32
33	Real Estate Taxes				0		0	0	0		33
34	Rent-Facility & Grounds				0		0	0	0		34
35	Rent-Equipment & Vehicles				0		0	0	0		35
36	Other (specify):*				0		0	0	0		36
37	TOTAL Ownership			0	0	68,307	68,307	0	68,307		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation				0		0	0	0		38
39	Ancillary Service Centers	3,489	85,095	15,967	104,551	(1,157)	103,394	58,310	161,704		39
40	Barber and Beauty Shops				0		0	0	0		40
41	Coffee and Gift Shops				0		0	0	0		41
42	Provider Participation Fee			56,940	56,940		56,940	0	56,940		42
43	Other (specify):*				0		0	0	0		43
44	TOTAL Special Cost Centers	3,489	85,095	72,907	161,491	(1,157)	160,334	58,310	218,644		44
	GRAND TOTAL COST										
45	(sum of lines 29, 37 & 44)	1,924,580	361,235	1,148,083	3,433,898	0	3,433,898	383,850	3,817,748		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

FOR LINES 1 THRU 28 AND 31 THRU 33, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINES 29 OR 35 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Num|Fayette County Hospital

8000846

Report Period Beginning: 7/1/00

Ending: 6/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 0		\$ 0	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	383,850		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 383,850		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 383,850		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fayette County Hospital

8000846

Report Period Beginning:

7/1/00

Ending:

6/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	27,623	0	0	0	0	0	0	0	0	0	0	27,623	7
8	TOTAL General Services	27,623	0	0	0	0	0	0	0	0	0	0	27,623	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	41,658	0	0	0	0	0	0	0	0	0	0	41,658	10
10a	Therapy	256,259	0	0	0	0	0	0	0	0	0	0	256,259	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	297,917	0	0	0	0	0	0	0	0	0	0	297,917	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotion	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	325,540	0	0	0	0	0	0	0	0	0	0	325,540	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/00 Ending: 6/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	58,310	0	0	0	0	0	0	0	0	0	0	58,310 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	58,310	0	0	0	0	0	0	0	0	0	0	58,310 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	383,850	0	0	0	0	0	0	0	0	0	0	383,850 45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

OWNERS		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITY	
Name	Ownership %	Name	City	Name	Type of Business
Facility Name Hospital Owner	100%	Alton Memorial Hospital	Alton, IL	Management Services	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

Schedule VI	Line	1	2	3	4	5	6	7	8	9
			Cost Per General Line			Cost to Related Organization		Operating Cost of Related Organization		Difference: Operating Cost of Related Organization minus 6
	1	V	19 Management Fees	\$	12,400	Alton Memorial Hospital	100%	\$ 12,400	\$	1
	2	V								2
	3	V								3
	4	V								4
	5	V								5
	6	V								6
	7	V								7
	8	V								8
	9	V								9
	10	V								10
	11	V								11
	12	V								12
	13	V								13
	14	V								14
	15	V								15
	16	V								16
	17	V								17
	18	V								18
	19	V								19
	20	V								20
	21	V								21
	22	V								22
	23	V								23
	24	V								24
	25	V								25
	26	V								26
	27	V								27
	28	V								28
	29	V								29
	30	V								30
	31	V								31
	32	V								32
	33	V								33
	34	V								34
	35	V								35
	36	V								36
	37	V								37
	38	V								38
	39	V								39
	40	V								40
	41	V								41
	42	V								42
	43	V								43
	44	V								44
	45	V								45
	46	V								46
	47	V								47
	48	V								48
	49	V								49
	50	V								50
	51	V								51
	52	V								52
	53	V								53
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	56	V								56
	57	V								57
	58	V								58
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	61	V								61
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	68	V								68
	69	V								69
	70	V								70
	71	V								71
	72	V								72
	73	V								73
	74	V								74
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	77	V								77
	78	V								78
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	80	V								80
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	82	V								82
	83	V								83
	84	V								84
	85	V								85
	86	V								86
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	88	V								88
	89	V								89
	90	V								90
	91	V								91
	92	V								92
	93	V								93
	94	V								94
	95	V								95
	96	V								96
	97	V								97
	98	V								98
	99	V								99
	100	V								100
	101	V								101
	102	V								102
	103	V								103
	104	V								104
	105	V								105
	106	V								106
	107	V								107
	108	V								108
	109	V								109
	110	V								110
	111	V								111
	112	V								112
	113	V								113
	114	V								114
	115	V								115
	116	V								116
	117	V								117
	118	V								118
	119	V								119
	120	V								120
	121	V								121
	122	V								122
	123	V								123
	124	V								124
	125	V								125
	126	V								126
	127	V								127
	128	V								128
	129	V								129
	130	V								130
	131	V								131
	132	V								132
	133	V								133
	134	V								134
	135	V								135
	136	V								136
	137	V								137
	138	V								138
	139	V								139
	140	V								140
	141	V								141
	142	V								142
	143	V								143
	144	V								144
	145	V								145
	146	V								146
	147	V								147
	148	V								148
	149	V								149
	150	V								150
	151	V								151
	152	V								152
	153	V								153
	154	V								154
	155	V								155
	156	V								156
	157	V								157
	158	V								158
	159	V								159
	160	V								160
	161	V								161
	162	V								162
	163	V								163
	164	V								164
	165	V								165
	166	V								166
	167	V								167
	168	V								168
	169	V								169
	170	V								170
	171	V								171
	172	V								172
	173	V								173
	174	V								174
	175	V								175
	176	V								176
	177	V								177
	178	V								178
	179	V								179
	180	V								180
	181	V								181
	182	V								182
	183	V								183
	184	V								184
	185	V								185
	186	V								186
	187	V								187
	188	V								188
	189	V								189
	190	V								190
	191	V								191
	192	V								192
	193	V								193
	194	V								194
	195	V								195
	196	V								196
	197	V								197
	198	V								198
	199	V								199
	200	V								200
	201	V								201
	202	V								202
	203	V								203
	204	V								204
	205	V								205
	206	V								206
	207	V								207
	208	V								208
	209	V								209
	210	V								210
	211	V								211
	212	V								212
	213	V								213
	214	V								214
	215	V								215
	216	V								216
	217	V								217
	218	V								218

Facility Name & ID Number Fayette County Hospital # 8000846 Report Period Beginning: 7/1/00 Ending: 6/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2		There were no payments to related parties.								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Fayette County Hospital

8000846 Report Period Beginning: 7/1/00

Ending: 6/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Fayette County HospitalStreet Address Seventh & TaylorCity / State / Zip Code Vandalia, IL. 62471Phone Number (618) 283-1232Fax Number (618) 283-4652

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals Served	133,773	6	\$ 759,279	\$ 142,923	95,193	\$ 540,304	1
2	3	Housekeeping	Sq. Ft.	67,020	21	354,574	193,565	19,583	103,605	2
3	4	Laundry	Pounds	679,315	11	236,063	91,786	440,908	153,216	3
4	6	Maintenance	Sq. Ft.	69,337	23	1,058,710	147,798	19,583	299,014	4
5	7	Cafeteria	FTE's	172	17	189,985	16,184	63	69,588	5
6	10	Medical Records	Patient Revenues	28,977,580	19	310,655	140,320	6,159,247	66,030	6
7	17	A&G	Accumulated Costs	12,746,361	30	2,056,248	660,087	2,312,158	372,998	7
8	22	Employee Benefits	Gross Salaries	6,242,102	24	1,208,691	113,429	1,494,811	289,448	8
9	30	Old Capital-Bldg	Sq. Ft.	120,580	26	157,529	0	19,583	25,584	9
10	30	Old Capital-Equip	Dollar Value	4,097	15	5,568	0	318	432	10
11	30	New Capital-Bldg	Sq. Ft.	120,580	26	501,181	0	19,583	81,395	11
12	30	New Capital-Equip	Dollar Value	461,981	26	758,052	0	24,119	39,576	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,596,535	\$ 1,506,092		\$ 2,041,190	25

Facility Name & ID Number **Fayette County Hospital**# **8000846**

Report Period Beginning:

7/1/00

Ending:

6/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$	\$			\$	1							
2												2							
3	No interest expense is included in Schedule V. 100% of the interest expense is hospital related.											3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$	0	\$	0		\$	0	9					
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	0	\$	0		\$	0	14					
15	TOTALS (line 9+line14)						\$	0	\$	0		\$	0	15					

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number: **Fayette County Hospital**# **8000846** Report Period Beginning **7/1/00** Ending: **6/30/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2000 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report	\$ <u>N/A</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ _____	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 0	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ _____	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$ _____	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$ _____	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6			\$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1996	8		
	1997	9		
	1998	10		
	1999	11		
	2000	12		

	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2000 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULA \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fayette County Hospital COUNTY Fayette

FACILITY IDPH LICENSE NUMBI8000846

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE() _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>0</u>	\$ <u>0</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Applicable to Tax Index Number Proper Total Tax Nursing Home

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30824 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

X., C&D, Fayette County Hospital District owns the facility and has an operating agreement with CH Allied Services, Inc.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Hospital & LTC	118,780	1968	\$ 22,958	1
2					2
3	TOTALS	118,780		\$ 22,958	3

Facility Name & ID Number Fayette County Hospital

8000846

Report Period Beginning:

7/1/00

Ending:

6/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6					Hospital & LTC bldg are owned by the District and are on their records.						6
7											7
8											8
	Improvement Type**										
9	Cabinet and countertop			1991	678	34	20	34		354	9
10	Light fixtures			1991	12,323	625	10	625		12,323	10
11	Carpeting			1991	1,157		10			1,157	11
12	Boiler control			1991	1,211	122	10	122		1,201	12
13	Ceiling tile			1994	5,152	520	10	520		3,375	13
14	Florescent lighting			1994	5,826	589	10	589		3,817	14
15	Light fixtures			1994	1,937	195	10	195		1,285	15
16	Ceiling tile			1994	2,635	266	10	266		1,726	16
17	LTC Remodeling-painting			1994	7,068	0	5			7,068	17
18	Manifold system			1995	2,234	225	10	225		1,428	18
19	Nurse call system			1996	14,194	1,431	10	1,431		7,638	19
20	Sliding door			1996	10,189	1,027	10	1,027		5,054	20
21	Nurse call system			1996	67,423	6,794	10	6,794		36,282	21
22	Remodel 3rd floor			1997	419,073	27,928	15	27,928		107,215	22
23	Cabinetry dining room			1997	4,097	273	5	273		1,138	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

555197 Page 12A

o Page 12B

o Page 12C

o Page 12D

o Page 12E

o Page 12F

o Page 12G

o Page 12H

o Page 12I

Facility Name & ID Number Fayette County Hospital

8000846

Report Period Beginning:

7/1/00

Ending:

6/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 555,197	\$ 40,029		\$ 40,029	\$ 0	\$ 191,061	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fayette County Hospital# 8000846Report Period Beginning: 7/1/00Ending: 6/30/01**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 293,692	\$ 27,507	\$ 27,507	\$ 0		\$ 163,665	71
72	Current Year Purchases	6,968	212	212	0		212	72
73	Fully Depreciated Assets	104,667	559	559	0		104,667	73
74					0			74
75	TOTALS	\$ 405,327	\$ 28,278	\$ 28,278	\$ 0		\$ 268,544	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 983,482	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,307	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,307	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 459,605	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Fayette County Hospital# 8000846Report Period Beginning: 7/1/00Ending: 6/30/01**XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2002 \$ _____

13. _____/2003 \$ _____

14. _____/2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

rent

Facility Name & ID Number Fayette County Hospital

8000846 Report Period Beginning: 7/1/00 Ending: 6/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES
☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE _____

B. EXPENSES**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOMEIn the box below record the amount of income your
facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				69,516		69,516	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Central Supply						13,864		13,864	13
14	TOTAL			\$		\$	\$ 83,380		\$ 83,380	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number **Fayette County Hospital**# **8000846**Report Period Beginning: **7/1/00**

Ending:

6/30/01**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/01**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 373,870	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		3,860,989	3
4	Supply Inventory (priced at)		94,352	4
5	Short-Term Investments			5
6	Prepaid Insurance		140,088	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Taxes Receivable		235,413	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 0	\$ 4,704,712	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		2,291,090	12
13	Land		141,609	13
14	Buildings, at Historical Cost		14,319,450	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		5,339,371	16
17	Accumulated Depreciation (book methods)		(10,830,206)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		6,599	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 0	\$ 11,267,913	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 0	\$ 15,972,625	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 567,482	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		493,317	29
30	Accrued Salaries Payable		943,180	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Affiliates		781,748	36
37	Due to Third Parties		77,483	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 0	\$ 2,863,210	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,807,171	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Self Insurance Liability		612,048	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 0	\$ 2419219	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 0	\$ 5282429	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10690196	\$ 10,690,196	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10690196	\$ 15,972,625	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,631,899	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1	\$ 10,631,899	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	230,682	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	117,187	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) FCH District Income	117,437	15
16	Other (describe) Settlement between FCH & FCHD	(407,009)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 58,297	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 10,690,196	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Numb Fayette County Hospital# 8000846Report Period Beginning: 7/1/00Ending: 6/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 30,488,926	1
2	Discounts and Allowances for all Levels	(14,053,548)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,435,378	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	475,785	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	44,796	14
15	Telephone, Television and Radio	36	15
16	Rental of Facility Space	44,531	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	213,744	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 778,892	23
D. Non-Operating Revenue			
24	Contributions	2,127	24
25	Interest and Other Investment Income***	(8,718)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (6,591)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,207,679	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	788,493	31
32	Health Care	1,896,675	32
33	General Administration	587,239	33
B. Capital Expense			
34	Ownership		34
C. Ancillary Expense			
35	Special Cost Centers	104,551	35
36	Provider Participation Fee	56,940	36
D. Other Expenses (specify):			
37	Hospital & Overhead Expenses	13,543,099	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,976,997	40
41	Income before Income Taxes (line 30 minus line 40)**	230,682	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 230,682	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Fayette County Hospital

8000846

Report Period Beginning: 7/1/00

Ending:

6/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,194	2,296	\$ 41,169	\$ 17.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,772	26,165	462,258	17.67	3
4	Licensed Practical Nurses	17,034	17,104	219,053	12.81	4
5	Nurse Aides & Orderlies	72,252	72,626	598,533	8.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,956	1,993	17,959	9.01	9
10	Activity Assistants	317	350	18,696	53.42	10
11	Social Service Workers	10,295	10,327	83,227	8.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,553	16,553	123,952	7.49	15
16	Dishwashers					16
17	Maintenance Workers	4,129	4,129	47,660	11.54	17
18	Housekeepers	13,245	13,269	90,319	6.81	18
19	Laundry	8,578	8,578	62,548	7.29	19
20	Administrator					20
21	Assistant Administrator	1,654	1,870	27,922	14.93	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,762	4,930	41,275	8.37	24
25	Vocational Instruction	6,122	6,159	85,477	13.88	25
26	Academic Instruction					26
27	Medical Director			4,532		27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	184,863	186,349	\$ 1,924,580 *	\$ 10.33	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchase? Yes
What was the average life used for new equipment added during this period? 5-10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedure consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. 56,940
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section _____ For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and personnel? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ernst & Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this been attached? No If no, please explain. Not received
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees